SERFF Tracking Number:	*IADC-126208822*	*State:*	*Arkansas*
Filing Company:	*Standard Security Life Insurance Company of New York*	*State Tracking Number:*	*42787*
Company Tracking Number:	*SSL STM 2009 ADDITIONAL FORMS*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.004 Short Term*
Product Name:	*SSL SHORT TERM MEDICAL 2009 ADDITIONAL FORMS*		
Project Name/Number:	*/*		

Filing at a Glance

Company: Standard Security Life Insurance Company of New York

Product Name: SSL SHORT TERM MEDICAL 2009 ADDITIONAL FORMS	SERFF Tr Num: IADC-126208822	State: ArkansasLH
TOI: H16G Group Health - Major Medical	SERFF Status: Closed	State Tr Num: 42787
Sub-TOI: H16G.004 Short Term	Co Tr Num: SSL STM 2009 ADDITIONAL FORMS	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Rosalind Minor
	Author: Shellie Howard	Disposition Date: 06/30/2009
	Date Submitted: 06/29/2009	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile: Not Filed
Project Number:	Date Approved in Domicile:
Requested Filing Mode:	Domicile Status Comments:
Explanation for Combination/Other:	Market Type:
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 06/30/2009	Explanation for Other Group Market Type:
	State Status Changed: 06/30/2009
Deemer Date:	Corresponding Filing Tracking Number:

Filing Description:

Group Short Term medical insurance product filing with situs state of DC - new forms. Please see cover letter for detailed explanation.

SERFF Tracking Number:	*IADC-126208822*	*State:*	*Arkansas*
Filing Company:	*Standard Security Life Insurance Company of New York*	*State Tracking Number:*	*42787*
Company Tracking Number:	*SSL STM 2009 ADDITIONAL FORMS*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.004 Short Term*
Product Name:	*SSL SHORT TERM MEDICAL 2009 ADDITIONAL FORMS*		
Project Name/Number:	*/*		

Company and Contact

Filing Contact Information

Shellie Howard, Forms Development & Compliance Specialist	howards@iacusa.com	
2101 W. Peoria Ave Phoenix, AZ 85029-4925	(602) 861-6070 [Phone]	

Filing Company Information

Standard Security Life Insurance Company of New York	CoCode: 69078	State of Domicile: New York
485 Madison Avenue New York, NY 10022-4141	Group Code: 450 Group Name:	Company Type: Life and Health State ID Number:
(212) 355-4141 ext. [Phone]	FEIN Number: 13-5679267	

Filing Fees

Fee Required?	Yes
Fee Amount:	$40.00
Retaliatory?	Yes
Fee Explanation:	$20.00 per form
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Standard Security Life Insurance Company of New York	$40.00	06/29/2009	28866775

SERFF Tracking Number:	*IADC-126208822*	*State:*	*Arkansas*
Filing Company:	*Standard Security Life Insurance Company of New York*	*State Tracking Number:*	*42787*
Company Tracking Number:	*SSL STM 2009 ADDITIONAL FORMS*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.004 Short Term*
Product Name:	*SSL SHORT TERM MEDICAL 2009 ADDITIONAL FORMS*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	06/30/2009	06/30/2009

SERFF Tracking Number:	*IADC-126208822*	*State:*	*Arkansas*
Filing Company:	*Standard Security Life Insurance Company of New York*	*State Tracking Number:*	*42787*
Company Tracking Number:	*SSL STM 2009 ADDITIONAL FORMS*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.004 Short Term*
Product Name:	*SSL SHORT TERM MEDICAL 2009 ADDITIONAL FORMS*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 06/30/2009
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*IADC-126208822*	*State:*	*Arkansas*
Filing Company:	*Standard Security Life Insurance Company of New York*	*State Tracking Number:*	*42787*
Company Tracking Number:	*SSL STM 2009 ADDITIONAL FORMS*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.004 Short Term*
Product Name:	*SSL SHORT TERM MEDICAL 2009 ADDITIONAL FORMS*		
Project Name/Number:	*/*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	3rd party authorization	Approved-Closed	Yes
Supporting Document	Statement of Variability	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Supporting Document	Original Policy Approval	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes
Form	Amendatory Endorsement	Approved-Closed	Yes

SERFF Tracking Number:	*IADC-126208822*	*State:*	*Arkansas*
Filing Company:	*Standard Security Life Insurance Company of New York*	*State Tracking Number:*	*42787*
Company Tracking Number:	*SSL STM 2009 ADDITIONAL FORMS*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.004 Short Term*
Product Name:	*SSL SHORT TERM MEDICAL 2009 ADDITIONAL FORMS*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number: SSL-STM-0609-APP

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	SSL-STM-0609-APP	Application/ Enrollment Form	Application	Initial			SSL-STM-0609-APP (ForFiling 061909).pdf
Approved-Closed	SSL-STM-EXCL-AE-0609	Certificate Amendment, Insert Page, Endorsement or Rider	Amendatory Endorsement	Initial			SSL-STM-EXCL-AE-0609 (ForFiling{061109}.pdf

[Plan Name]

STANDARD SECURITY LIFE INSURANCE COMPANY OF NEW YORK
SHORT TERM MEDICAL INSURANCE APPLICATION

COMPLETE THE FOLLOWING TO INSURE YOURSELF:

Applicant:

Last Name _____

First Name _____

Date of Birth _____ Age _____ Sex _____

Social Security Number_____

Occupation _____

Telephone _____

Street Address _____

_____

City _____ State _____ Zip_____

Billing Address (if different) _____

_____

City _____ State ____ Zip_____

E-mail address _____

COMPLETE THE FOLLOWING TO INSURE YOUR SPOUSE AND/OR CHILDREN:

Spouse:

Last Name _____

First Name _____

Date of Birth _____ Age _____ Sex ____

Social Security Number _____

Occupation _____

Child(ren)Name _____

Date of Birth _____ Age _____

Social Security Number _____

Child(ren)Name _____

Date of Birth _____ Age _____

Social Security Number _____

Child(ren)Name _____

Date of Birth _____ Age_____

Social Security Number _____

COMPLETE THE FOLLOWING PLAN CHOICES:

Coverage Effective Date:

[□ Day after US Post Office Date Stamp

□ Later Effective Date: _____

● No more than [60] days in advance]

Coverage Length:

[□ **Single Payment:** *Specify number of days of coverage*

____ days *(minimum [30] days, maximum [365] days)* or

□ **Monthly Payment:**

□ Up to [6] Months

□ Up to [12] Months]

□ **[Secure] STM Plan Coinsurance:**

[□ 80/20 of $5,000 □ 50/50 of $5,000 □ 80/20 of $10,000 □ 50/50 of $10,000 □ 100%]*

*100% not available with $250 or $1,000 Deductible]]

Deductible:

[□$250 □ $500 □ $1,000 □ $2,500 □ $5,000 □ $10,000 □ $25,000]

[□ **Daily Deductible STM Plan Coinsurance:**

Not applicable

Deductible:

□ $250 □ $500 □ $750 □ $1,000]

[□ **Optional Supplemental Accident Benefit**

□ $500 □ $1,000]

[Method of Payment

□ Check or Money Order

□ Credit Card

□ Monthly Automatic Bank Withdrawal]

ANSWER THE FOLLOWING MEDICAL HISTORY QUESTIONS:

Misstatements and omissions may be a material misrepresentation and a basis for rescission of coverage. In the event of rescission; (1) coverage will be void as of the Effective Date; (2) all premiums paid will be refunded; (3) all claims that have been submitted will be denied; (4) if any claims have been paid, the amount of claims paid will be deducted from any premium refund due.

1. Will there be any other group or individual major medical health insurance in force on the policy effective date? ..... □ Yes □ No
2. Is the proposed insured, spouse, or any dependent child now pregnant? ..... □ Yes □ No
3. Are you or any person applying for coverage currently eligible for Medicaid? ..... □ Yes □ No

[4. Are you or any person applying for coverage currently over [300] pounds if male or over [250] pounds if female? ..... □ Yes □ No]

[5.] Within the past [5] years have you or any person applying for coverage been aware of, received an abnormal test report for, been diagnosed with, been treated by or received follow-up care with a member of the medical profession, taken medication for or had a device surgically implanted or in place for:

■ heart disorder, heart attack, coronary artery disease, coronary bypass or stent ■ peripheral vascular disease or carotid artery disease ■ stroke or other neurological disorder ■ cancer or tumor	■ paraplegia, quadriplegia or multiple sclerosis ■ stem cell transplant ■ emphysema or COPD (chronic obstructive pulmonary disease) ■ diabetes ■ liver disorder	■ kidney disorder other than stones ■ degenerative disc disease or herniated disc ■ rheumatoid or psoriatic arthritis ■ degenerative joint disease of the knees or hips ■ alcohol or drug abuse or dependency ■ hemophilia

..... □ Yes □ No

[6.] Have you or any person proposed for coverage been diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS-related complex, or any other immune system disorder? Answer this question "no" if you have tested positive for HIV but have not developed symptoms of the disease AIDS ....□ Yes □ No

[[7.]Has any person proposed for coverage not been a legal resident of the United States for the last [12] consecutive months?..... □ Yes □ No]

([NOTE: IF "YES IS ANSWERED ON ANY QUESTION 1 THROUGH [7], COVERAGE CANNOT BE ISSUED].)

ACCEPTANCE AND ACKNOWLEDGEMENT:

A. I agree that coverage will not become effective for any person whose medical history changes prior to the persons Effective Date, such that the person's answer would be "yes" to any of the Medical History questions in this application. If such person is the Applicant, coverage is automatically declined for all persons included in this application.
B. I hereby request coverage under the policy issued to the group policyholder. I agree to all terms of the group policy if the coverage applied for becomes effective.
C. I understand that the agent or broker who solicited this application and upon whose explanation of benefits, limitations or exclusions we relied (1) was acting as an independent contractor and not as an agent of the Insurance Company; (2) was retained by me as my agent; and (3) has no right to alter the application, bind or approve coverage or alter any of the terms or conditions of the policy.
D. I certify that (1) I have read this application; (2) all of my (our) answers are within my (our) personal knowledge; and (3) all of my (our) answers are complete, true and correct.
E. I agree to immediately notify the insurer of any changes in any of the information contained in this application which may occur prior to the Effective Date of coverage.
F. I understand that health insurance benefits are excluded for pre-existing conditions and this coverage will not pay benefits for a disease or physical condition that I now have or have had within [5] years of my application for coverage.
G. I understand that cancellation of this coverage within the 10 Day Right to Return the Certificate provision as stated in the Certificate of Insurance will result in a refund of premiums only. [Any administrative fees or other fees that may apply will not be refunded].

Signature of Applicant or (Legal Guardian): _____ **Date:** _____

Signature of Spouse: _____ **Date:** _____

Fraud Warning: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, or conceals information for the purpose of misleading may be guilty of insurance fraud and subject to criminal and/or civil penalty.

[Arkansas Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.]

District of Columbia Residents: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

[Kentucky, Ohio and Pennsylvania Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.]

[New Mexico Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.]

[Oklahoma Residents: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.]

[Tennessee Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage.]

STANDARD SECURITY LIFE INSURANCE COMPANY OF NEW YORK
[485 Madison Avenue, New York, NY 10022]

AMENDATORY ENDORSEMENT

This Amendatory Endorsement made a part of the Group Policy and Certificate to which it is attached. The provisions of this Amendatory Endorsement are effective on the Effective Date stated herein and will expire concurrently with the Group Policy and Certificate unless otherwise terminated. In consideration of issuance, the Group Policy and Certificate is hereby amended and modified, as follows:

Under the Section entitled "Limitations and Exclusions" the exclusion pertaining to expenses incurred during the first 6-months after the Effective Date of coverage for a Covered Person is deleted in its entirety.

This Rider is endorsed and made part of the Group Policy and Certificate as of Your Effective Date of coverage.

This Rider is subject to all provisions of the Policy and Certificate which are not in conflict with the provisions of this Amendatory Endorsement. Nothing in this Endorsement will be held to vary, alter, waive, or extend any of the terms, conditions, provisions, agreements, or limitations of the Policy other than stated above.

IN WITNESS WHEREOF, the Insurance Company has caused this Rider to be signed by its President.

STANDARD SECURITY LIFE INSURANCE COMPANY OF NEW YORK

Rachel Lipari
President

Adam C. Vandervoort
Secretary

SERFF Tracking Number:	*IADC-126208822*	*State:*	*Arkansas*
Filing Company:	*Standard Security Life Insurance Company of New York*	*State Tracking Number:*	*42787*
Company Tracking Number:	*SSL STM 2009 ADDITIONAL FORMS*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.004 Short Term*
Product Name:	*SSL SHORT TERM MEDICAL 2009 ADDITIONAL FORMS*		
Project Name/Number:	*/*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*IADC-126208822*	*State:*	*Arkansas*
Filing Company:	*Standard Security Life Insurance Company of New York*	*State Tracking Number:*	*42787*
Company Tracking Number:	*SSL STM 2009 ADDITIONAL FORMS*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.004 Short Term*
Product Name:	*SSL SHORT TERM MEDICAL 2009 ADDITIONAL FORMS*		
Project Name/Number:	*/*		

Supporting Document Schedules

Satisfied -Name: Flesch Certification
Review Status: Approved-Closed 06/30/2009
Comments:
Attachments:
ARCertificate of Compliance 062909.pdf
SSL STM Readability Certification (062909).pdf

Satisfied -Name: Application
Review Status: Approved-Closed 06/30/2009
Comments:
Attachment:
SSL-STM-0609-APP (ForFiling 061909).pdf

Satisfied -Name: 3rd party authorization
Review Status: Approved-Closed 06/30/2009
Comments:
Attachment:
SSL Filing Authorization Letter 0309.pdf

Satisfied -Name: Statement of Variability
Review Status: Approved-Closed 06/30/2009
Comments:
Attachment:
Statement of Variability 062909.pdf

Satisfied -Name: Cover Letter
Review Status: Approved-Closed 06/30/2009
Comments:
Attachment:
SSL(AR)filing letter 062909.pdf

SERFF Tracking Number:	*IADC-126208822*	*State:*	*Arkansas*
Filing Company:	*Standard Security Life Insurance Company of New York*	*State Tracking Number:*	*42787*
Company Tracking Number:	*SSL STM 2009 ADDITIONAL FORMS*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.004 Short Term*
Product Name:	*SSL SHORT TERM MEDICAL 2009 ADDITIONAL FORMS*		
Project Name/Number:	*/*		

Satisfied -Name: Original Policy Approval

Review Status: Approved-Closed 06/30/2009

Comments:

Attachment:

Original Policy Approval.pdf

Certificate of Compliance with Arkansas Rule and Regulation 19

Insurer: Standard Security Life Insurance Company of New York (SSL)

Form Number(s):

SSL-STM-0609-APP
SSL-EXCL-AE-0609

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirement of Rule and Regulation 19.

Signature of Company Officer:

Adam Vandervoort
Name

Secretary
Title

06/29/09
Date

Standard Security Life Insurance Company of New York
485 Madison Avenue
New York, NY 10022-5872
Telephone: (212) 355-4141

June 29, 2009

READABILITY CERTIFICATION

NAIC Company Number: 69078
NAIC Group Number: 0450
FEIN Number: 13-5679267

SSL-STM-EXCL-AE-0609	Amendatory Endorsement
SSL-STM-0609-APP	Application

I hereby certify that the above captioned forms have a minimum Flesch Index Score of 51 and comply with the readability requirements of this State. Schedules, captions, indexes, defined terms and the Company references were deleted prior to determining the Flesch Index Score.

Adam C. Vandervoort
Secretary

[Plan Name]

STANDARD SECURITY LIFE INSURANCE COMPANY OF NEW YORK
SHORT TERM MEDICAL INSURANCE APPLICATION

COMPLETE THE FOLLOWING TO INSURE YOURSELF:

Applicant:

Last Name _____

First Name _____

Date of Birth _____ Age _____ Sex _____

Social Security Number_____

Occupation _____

Telephone _____

Street Address _____

_____

City _____ State _____ Zip_____

Billing Address (if different) _____

_____

City _____ State ____ Zip_____

E-mail address _____

COMPLETE THE FOLLOWING TO INSURE YOUR SPOUSE AND/OR CHILDREN:

Spouse:

Last Name _____

First Name _____

Date of Birth _____ Age _____ Sex ____

Social Security Number _____

Occupation _____

Child(ren)Name _____

Date of Birth _____ Age _____

Social Security Number _____

Child(ren)Name _____

Date of Birth _____ Age _____

Social Security Number _____

Child(ren)Name _____

Date of Birth _____ Age_____

Social Security Number _____

COMPLETE THE FOLLOWING PLAN CHOICES:

Coverage Effective Date:

[□ Day after US Post Office Date Stamp

□ Later Effective Date: _____

● No more than [60] days in advance]

Coverage Length:

[□ **Single Payment:** *Specify number of days of coverage*

____ days *(minimum [30] days, maximum [365] days)* or

□ **Monthly Payment:**

□ Up to [6] Months

□ Up to [12] Months]

□ **[Secure] STM Plan Coinsurance:**

[□ 80/20 of $5,000 □ 50/50 of $5,000 □ 80/20 of $10,000 □ 50/50 of $10,000 □ 100%]*

*100% not available with $250 or $1,000 Deductible]]

Deductible:

[□$250 □ $500 □ $1,000 □ $2,500 □ $5,000 □ $10,000 □ $25,000]

[□ **Daily Deductible STM Plan Coinsurance:**

Not applicable

Deductible:

□ $250 □ $500 □ $750 □ $1,000]

[□ **Optional Supplemental Accident Benefit**

□ $500 □ $1,000]

[Method of Payment

□ Check or Money Order

□ Credit Card

□ Monthly Automatic Bank Withdrawal]

ANSWER THE FOLLOWING MEDICAL HISTORY QUESTIONS:

Misstatements and omissions may be a material misrepresentation and a basis for rescission of coverage. In the event of rescission; (1) coverage will be void as of the Effective Date; (2) all premiums paid will be refunded; (3) all claims that have been submitted will be denied; (4) if any claims have been paid, the amount of claims paid will be deducted from any premium refund due.

1. Will there be any other group or individual major medical health insurance in force on the policy effective date? ..... □ Yes □ No
2. Is the proposed insured, spouse, or any dependent child now pregnant? ..... □ Yes □ No
3. Are you or any person applying for coverage currently eligible for Medicaid? ..... □ Yes □ No

[4. Are you or any person applying for coverage currently over [300] pounds if male or over [250] pounds if female? ..... □ Yes □ No]

[5.] Within the past [5] years have you or any person applying for coverage been aware of, received an abnormal test report for, been diagnosed with, been treated by or received follow-up care with a member of the medical profession, taken medication for or had a device surgically implanted or in place for:

■ heart disorder, heart attack, coronary artery disease, coronary bypass or stent ■ peripheral vascular disease or carotid artery disease ■ stroke or other neurological disorder ■ cancer or tumor	■ paraplegia, quadriplegia or multiple sclerosis ■ stem cell transplant ■ emphysema or COPD (chronic obstructive pulmonary disease) ■ diabetes ■ liver disorder	■ kidney disorder other than stones ■ degenerative disc disease or herniated disc ■ rheumatoid or psoriatic arthritis ■ degenerative joint disease of the knees or hips ■ alcohol or drug abuse or dependency ■ hemophilia

..... □ Yes □ No

[6.] Have you or any person proposed for coverage been diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS-related complex, or any other immune system disorder? Answer this question "no" if you have tested positive for HIV but have not developed symptoms of the disease AIDS ....□ Yes □ No

[[7.]Has any person proposed for coverage not been a legal resident of the United States for the last [12] consecutive months?..... □ Yes □ No]

([NOTE: IF "YES IS ANSWERED ON ANY QUESTION 1 THROUGH [7], COVERAGE CANNOT BE ISSUED].)

ACCEPTANCE AND ACKNOWLEDGEMENT:

A. I agree that coverage will not become effective for any person whose medical history changes prior to the persons Effective Date, such that the person's answer would be "yes" to any of the Medical History questions in this application. If such person is the Applicant, coverage is automatically declined for all persons included in this application.
B. I hereby request coverage under the policy issued to the group policyholder. I agree to all terms of the group policy if the coverage applied for becomes effective.
C. I understand that the agent or broker who solicited this application and upon whose explanation of benefits, limitations or exclusions we relied (1) was acting as an independent contractor and not as an agent of the Insurance Company; (2) was retained by me as my agent; and (3) has no right to alter the application, bind or approve coverage or alter any of the terms or conditions of the policy.
D. I certify that (1) I have read this application; (2) all of my (our) answers are within my (our) personal knowledge; and (3) all of my (our) answers are complete, true and correct.
E. I agree to immediately notify the insurer of any changes in any of the information contained in this application which may occur prior to the Effective Date of coverage.
F. I understand that health insurance benefits are excluded for pre-existing conditions and this coverage will not pay benefits for a disease or physical condition that I now have or have had within [5] years of my application for coverage.
G. I understand that cancellation of this coverage within the 10 Day Right to Return the Certificate provision as stated in the Certificate of Insurance will result in a refund of premiums only. [Any administrative fees or other fees that may apply will not be refunded].

Signature of Applicant or (Legal Guardian): _____ **Date:** _____

Signature of Spouse: _____ **Date:** _____

Fraud Warning: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, or conceals information for the purpose of misleading may be guilty of insurance fraud and subject to criminal and/or civil penalty.

[Arkansas Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.]

District of Columbia Residents: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

[Kentucky, Ohio and Pennsylvania Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.]

[New Mexico Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.]

[Oklahoma Residents: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.]

[Tennessee Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage.]

Standard Security Life Insurance Company of New York
485 Madison Avenue
New York, NY 10022-5872
Telephone: (212) 355-4141

March 23, 2009

RE: Standard Security Life Insurance Company of New York

NAIC Company Number:	69078
NAIC Group Number:	0450
FEIN Number:	13-5679267

AUTHORIZATION STATEMENT

Standard Security Life Insurance Company of New York ("SSLICNY") hereby authorizes Insurers Administrative Corporation ("IAC"), to represent us in the submission of accident and health insurance Group Policy Forms, and related forms and rates, and to negotiate with the Department for their approval.

Sincerely,

Adam C. Vandervoort
Secretary

SHORT TERM MEDICAL PRODUCT
STATEMENT OF VARIABILITY

Variability will never be used if it would conflict with the minimum requirements as mandated by State or Federal law. All state mandated benefits within text that is bracketed would not be changed to an amount below that which is mandated by the state. Variability is provided to offer greater flexibility in plan design by the insurer.

All text within brackets is variable as follows:

APPLICATION SSL-STM-0609-APP
Variability in application is for marketing names, and plan options.
The Plan choices (column 2) is based on plan designs being offered by the insurer and as selected by the applicant. The questions #5 (weight question) and #7 (US residency) are both completely variable so that the question(s) can be included in their entirety or completely omitted contingent on the insurer's plan designs and whether the question(s) will be applicable to the plan being marketed. As a result of question #5 being bracketed, question #6 and #7; as well as #9 are bracketed, but only the numbers, not the entire question to allow renumbering if any of the questions are not used due to plan design.

Insurers Administrative Corporation
MEMBER OF THE IHC GROUP
NYSE: IHC

June 29, 2009

Honorable Julie Benafield-Bowman
Insurance Commissioner
State of Arkansas
Arkansas Department of Insurance
1200 W. Third St.
Little Rock, AR 72201-1904

RE: **Standard Security Life Insurance Company of New York**
NAIC #: 69078
NAIC Group #: 0450
FEIN #: 13-5679267
Group Short Term Medical Insurance Policy – SSL-STMP-1104

Forms:

Amendatory Endorsement:	SSL-STM-EXCL-AE-0609
Short Term Medical Insurance Application:	SSL-STM-0609-APP

Dear Commissioner Benafield-Bowman :

The above referenced Short Term Medical Insurance Policy et al, was approved by your Department on January 18, 2005. For your convenience and confirmation, attached is a copy of the Department's January 18, 2005 stamped approval.

We are submitting the above referenced new forms for your review and approval. These two new forms are for use with the above referenced Short Term Medical Insurance Policy. A Filing Letter of Authorization from Standard Security Life Insurance Company of New York authorizing us, Insurers Administrative Corporation {"IAC"}, to represent them in this filing and to work with the Department for the purposes of obtaining Departmental approval is enclosed.

The following is a summary of each form being filed:

Form #SSL-STM-EXCL-AE-0609 (Amendatory Endorsement). This form is new and does not replace any existing form. The Amendatory Endorsement amends the Policy to remove the 6-month exclusion for certain conditions.

Form #SSL-STM-0609-APP (Short Term Medical Insurance Application). This form is new and is not intended to replace any form previously approved by your Department.

Variable text is bracketed and may vary from case-to-case. Variable text will never exclude or limit provisions required by your jurisdiction.

Your favorable consideration and expeditious approval of these new forms is respectfully requested. Please let me know if you have any questions or if additional information is desired in connection with this filing.

Sincerely,

Shellie Howard

Shellie Howard
Form Development & Compliance Specialist
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January 4, 2005

Honorable Mike Pickens
Insurance Commissioner
State of Arkansas
Arkansas Department of Insurance
1200 W. Third St.
Little Rock, AR 72201-1904

RE: STANDARD SECURITY LIFE INSURANCE COMPANY OF NEW YORK - NAIC# 69078
FEIN# 13-5679267
Group Short Term Medial Insurance Product Filing

Enclosed Forms:

Group Policy	SSL-STMP-1104
Certificate	SSL-STM-1104
Variable Endorsement	SSL-AE-1104
Accident Rider	SSL-ADB-1104
Application	SSL-STM-1104-APP
Reenrollment Application	SSL-STM-1104-REAPP
Policyholder Application	SSL-STMP-1104-APP
Authorization Letter	

Dear Commissioner Pickens:

The enclosed forms are being submitted for approval as a Group Short Term Medical product for a group situsued outside your states jursidiction. The situsued state of the group is DC and the forms are being filed simultaneously with your state. These are new forms and not intended to replace any forms previously filed with your Department.

Insurance Compliance Consultants, Inc. has been retained by Standard Security Life Insurance Company of New York to file the above mentioned filing in your state. Please address any future correspondence and/or approvals to my attention at the address shown above.

This product provides short term medical expense coverage to insured members and their dependents. As you know, the Health Insurance Portability and Accountability Act (HIPAA) specifically exempts short-term medical contracts from compliance with any such requirements. Additionally, this product will *not* be issued to employer groups. Premiums will be paid solely by the individual insured.

The coverage period is for 12-months or less and is non-renewable. The specific benefit design will be elected by the Policyholder. The Policyholder will apply for coverage via the Policyholder Application. Person's who are members of the association will complete the Application and be issued the Certificate.

The Variable Endorsement will be used to make changes within the bracketed areas of the Policy and Certificate after it becomes effective. For example, a benefit maximum may be changed. This would be shown in the Endorsement to add that change to the Policy and Certificate.

Variable text is bracketed and may vary from case-to-case. Amounts may vary, or provisions may be modified, to fit a specific policyholder's request. The bracketed text shows the most restrictive provision that would be offered to the insured. Variable text will never exclude or limit provisions required by your jurisdiction. If a change in a non-variable area is needed, the section will be refiled. We intend to refile only the section being changed and not the entire product.

Please note the following:

- Standard Security Life Insurance Company of New York is domiciled in New York.
- This product will be solicited through properly licensed agents and brokers and/or mass marketed.
- Forms are being submitted in final printed format. Printing is subject to changes in ink, paper stock, page numbers, margins, position and format. Printing standards will never be less that that required by your state. We would like to reserve the option of using these forms electronically.

If you have any questions, or need additional information, please contact me by telephone at 815-316-6714 or email at brendadawson@inscompliance.com. My fax number is 815-316-6720. Your immediate consideration of this filing is appreciated.

Sincerely,

Brenda Dawson

Brenda Dawson, FLMI, AIRC, ACS
Authorized Representative
Insurance Compliance Consultants, Inc.

Enclosures